Request for Forms

Completion Instructions:

- **Quantity** – Indicate quantity requested in the **Quantity Ordered** column.
- **Shipping Address** – Type/print your GHP provider number, provider name, requestor's name (if different from provider name) and address in the **FROM** box.
  NOTE: *We must have a* ***STREET ADDRESS;*** *UPS will not ship to a post office box.*
- **Mail this form to:** – GHP, P. O. Box 5000, McRae, GA 31055

Item	Form Type	Qty. Ordered
DMA-6	Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded	
DMA-44	Home Health Patient Profile	
DMA-59	Authorization for Nursing Facility Reimbursement	
DMA-69	Informed Consent for Voluntary Sterilization	
DMA-80	Prior Authorization Request	
DMA-81	Prior Approval for Medical Service	
DMA-276	Statement of Medical Necessity	
DMA-311	Certification of Necessity for Abortion	
DMA-312	Coordination of Benefits/Third Party Liability Accident Information Report	
DMA-380	Optical Device Prescription	
DMA-410	COB Notification Form	
DMA-501	Adjustment	
DMA-520	Provider Inquiry Form	
DMA-521	Hospice Referral Form for Non-Hospice Related Services	
DMA-550	Newborn Medicaid Certification	
DMA-610	Prior Authorization Request	
DMA-613	Level I Applicant/Resident I.D. Screening Instrument	
DMA-615	ESRD Enrollment Application	
DMA-632	Presumptive Eligibility Determination for Pregnancy-Related Care	
DMA-633	Change Form /Temporary Medicaid Card	
DMA-634	Notice of Action	
DMA-635	Post Partum Home Visit Mother Assessment	
DMA-637	Post Partum Teaching Guide	
DMA-638	Letter of Understanding	
DMA-639	Model Waiver Assessment	
DMA-641	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (6-7 month visit)	
DMA-642	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (11-12 month visit)	

Item	Brochure Type	English	Spanish
HC Brochure	Health Check: Keeping Georgia's Children Healthy		
HCS Booklet	Home and Community Services: A Guide to Medicaid Waiver Programs		
UM Booklet	Understanding Medicaid: A Handbook About Medicaid Services		

FROM

Provider Medicaid ID Number (10-digits)										

Requestor's Name (Last, First, MI) **Telephone Number** **Ext.**

Provider/Facility Name **Attn**

Street Address

City, State, Zip Code

DMA 292 (Rev. 4/10)